less costly than UFH. These findings were robust with respect to changes in the background risk of thromboembolism and risk of death from competing causes.
CONCLUSIONS: Thromboprophylaxis with enoxaparin represents a cost-effective use of health-care resources and dominates strategies involving the use of UFH in acutely-ill medical inpatients.

PCV15

TOTAL DIRECT MEDICAL AND DRUG COSTS OF NON-ADHERENCE TO STATIN THERAPY WITHIN THE FIRST YEAR OF TREATMENT

Peterson AM, Sanoski CA, McGhan WF
Philadelphia College of Pharmacy, Philadelphia, PA, USA

OBJECTIVE: Controlled trials have demonstrated the positive impact of statins on health outcomes in hyperlipidemic patients. However, few studies analyzed the cost-effectiveness of adherence to statins.
METHODS: Data were retrospectively gathered from a commercial, integrated pharmacy/medical claims database. Patients over 18 years with at least two statin claims, a 120-day benefit history, and a 360-day continuous enrollment were selected for inclusion. Age, gender, and concomitant drug/disease information were collected. Adherence to statins was calculated as (total days supplied)/(last claim date—first claim date + last days supply)*100. Total medical and drug costs, (TMDC), including drug, hospital, physician visit and lab information, were used to calculate per-member-per-month (PMPM) costs during the follow-up period. Number of patients and days to institutionalization for a disease-related event (DRE) was determined and the costs for DRE were calculated. ANOVA, or a non-parametric equivalent, was used to test results across adherence quintiles.
RESULTS: 2317 patients (62% male) were included in this analysis. The mean sample age was 53 with patients taking an average of 7.1 medications concomitantly. 72.8% of patients were less than 80% adherent and nearly 1/3 were less than 39% adherent. The median TMDC for the sample was $379 PMPM, with costs significantly decreasing as adherence decreased ($P < 0.0001$). The median cost for DRE was $313 PMPM, and also decreased as adherence decreased, except for the >100% adherent patients whose costs were less than the median, though not significantly ($P = 0.703$). Adherence was not significant in affecting the days to DRE ($P = 0.4559$).
CONCLUSION: Although statins reduce cardiovascular events over multiple years, this study confirms that cost savings cannot be expected in the first year. If drug costs are included in the total costs, one cannot expect an increase in adherence to decrease the total direct health care costs in the first year of treatment.

PCV16

DIFFERENCES IN HOSPITAL LENGTH-OF-STAY, CHARGES AND MORTALITY IN CONGESTIVE HEART FAILURE PATIENTS

Joshi AV[1], D'Souza AO[2], Madhavan SS[3]
[1]West Virginia University/Pfizer, Morgantown, WV, USA;
[2]West Virginia University/Aventis, Morgantown, WV, USA;
[3]West Virginia University, Morgantown, WV, USA

OBJECTIVE: To demonstrate differences in hospital length-of-stay (LOS), charges, and mortality in CHF patients by hospital and patient characteristics using the 1997 Hospital Cost and Utilization Project (HCUP) database.
METHODS: Hospitalizations with ICD-9-CM codes for CHF were extracted from a 10% random HCUP sample to yield 19,746 hospitalizations representing 22 states. Hospital variables included region (Northeast, Midwest, South, West), location (urban/rural), teaching/non-teaching status, ownership (government, for-profit, not for-profit), and hospital size (small, medium, large). Patient variables included age (< = 50 years, 51–65 years, >65 years), race (white, African-American, others), gender, income (<$25,000, $25,000–$30,000, $30,000–$35,000, >$35,000), number of comorbidities, and payer status (Medicare, Medicaid, private/HMO, self-pay). One-way ANOVA and chi-square statistics were used to test for significant ($p < = 0.05$) differences.
RESULTS: On average, CHF patients incurred charges of $11,866 per hospitalization. The mean LOS per hospitalization was 5.83 days and the in-hospital mortality was 4.6 percent. LOS and hospital charges increased with disease severity when patients were classified into 3 severity levels based on the number of comorbidities. Self-pay patients had the longest LOS (8.69 days) but the lowest charges ($11,418), and privately-insured/HMO patients had the shortest LOS (5.33 days) but the highest charges ($13,381). For-profit hospitals reported the highest mean charges, followed by private/not profit and government hospitals. Mortality did not vary by region, location, ownership and teaching status. Elderly patients (>65) had significantly higher charges as compared to younger patients (<50) ($ 13,817 vs. $11,607) and had higher mortality (5.4% vs. 1.6%). High-income patients incurred significantly higher charges as compared to low-income patients ($13,456 vs. $10,840). Whites had higher mortality (5.1%) as compared with others (4.6%) and African-Americans (2.8%). LOS and charges did not vary by race or gender.
CONCLUSION: Hospital LOS, charges and mortality in CHF patients show marked differences when compared by patient and hospital characteristics.

PCV17

COST-EFFECTIVENESS OF RAMIPRIL (ALTACE) IN PATIENTS POST-REVASCULARIZATION

Mallick R, Fincher C
Wyeth-Ayerst Research, Collegeville, PA, USA